

## **Kentucky Board of Nursing**

312 Whittington Pky, Suite 300 Louisville, KY 40222-5172

Phone: 502-429-3300 or 800-305-2042 Fax: 502-429-3311

## **VERIFICATION OF LICENSURE**

**ATTACHMENT 2** 

Complete the top section only, and send this form and the appropriate fee to the board of nursing in the state where you received your original license. (Contact your original state of licensure for the appropriate fee.)

Note: Be sure to check the NurSys Form to determine if you should complete Attachment 2 or the NurSys Form.

	REGISTERED NURSE   LICENSED PRACTICAL NURSE
Last Name:	
First Name:	M.I.
Maiden Name:	
Street:	
City:	State: Zip:
Social Se	ecurity #: License #: Date of Birth:
─ To Be Com	npleted by the Board of Nursing in the State of Your Original Licensure
Licensed in the	By Endorsement O Date License Issued:
Type of Prograi	m: Vocational O RN Diploma ADN/AAS BSN Other List:
Name of Nursin Program:	ng
City of PON:	State of PON:
Date of Comple	etion (Month/Year): Is/Was this an approved program? Yes No
	e ever been revoked, suspended, restricted, limited, probated, or otherwise disciplined?  Yes No Ontach a copy of any order by the Board.
Is there any act	tion pending on this license? If yes, please attach an explanation.
Did this individu	ual take and pass either the State Board Test Pool Examination (SBTPE) or the National Council Licensure Examination
`	Series #: No O If no, please explain
I certify that th	ne above information for the above named nurse represents accurately the information on file with the board.
Signed and the	e board seal affixed on this date: S E A L
Signature	
Title	5/02